NORTH DAKOTA MEDICAID PAYMENT ALERT

TO: CLAIMS AUDITOR
CLAIMS PROCESSING
MEDICAL SERVICES DIVISION
600 EAST BOULEVARD AVENUE DEPT 325
BISMARCK ND 58505-0250

FROM: (Provider Name and Address)

NAME	MEDICAID ID NUMBER	BIRTH DATE	PROVIDER NUMBER	ADMISSION DATE	STATE OFFICE USE

Signature:

Date of Report:

Note: This form must be submitted on all new Medicaid recipients and recipients who apply for Medicaid after review is completed by Dual Diagnosis Management.

Copies of this form can be printed at the following:

http://www.nd.gov/humanservices/services/medicalserv/medicaid/docs/medicaid-payment-alert.pdf

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